
WORKSHOP SUMMARY: WHAT CAN BE LEARNED FROM OTHER HEALTH PROFESSIONALS*

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A FEW weeks ago I lunched in the doctor's dining room at my medical center and happened to sit with some of my surgical colleagues who were advising a junior member of their group why he did not need a consulting room. They said it is fatal to have a consulting room; patients settle into a chair in a consulting room, and that slows you down. Sometimes you can never get them out. Finally, one of the senior surgeons said, "As a matter of fact, I have a rule that I never let them sit down even in the examining room, because if you can keep them on their feet then you can get them out and get the next one in." This points up the need for other health professionals than surgeons in patient education and certainly we all have a lot to learn from them.

We, too, had three presentations. The first was by Kathleen Bower, who is vice chairman of nursing at New England Medical Center, which is a closed group practice, as most of you know. The patient education program is primarily a nursing function, and nurses take the primary responsibility for it. They do it, however, in support of physicians and also in behalf of patients who are seeking to allay anxiety, to learn and to participate in their own treatment programs. At New England Medical Center this is considered an integral part of patient care and is coordinated with all the health personnel in the Center. The program has two characteristics: a supporting function and a monitoring function. The supporting function is an initial assessment by the nurse of the patient's coping skills and social supports. An integrated medical record reports all the information from others caring for the patient. There are standardized teaching plans. Many of these units are specialty based, i.e., patients are taught self-catheterization, a formula for

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crutch walking and so forth. There are written guidelines for the nurses in all their teaching. And they have advanced workshops where they take up various techniques of patient education and strategies to adapt methods to the needs of the patients. For monitoring there are rounds with the head nurse weekly. There is an audit mechanism, a peer audit of nurse-to-nurse, and a monthly audit on discharge planning. The six-weeks evaluation is basic, and then there is a three-month evaluation, a six-month evaluation, and a yearly evaluation. They try to keep patients under surveillance for as long as they are caring for them. House physicians play a key role; but since they rotate services, the nurse's relationship with the attending physician is closer as regards patient education.

Miss Bower listed the advantages and disadvantages. The advantages are that it facilitates tailoring of plans to patients. Costs for this activity are dispersed throughout the institution. Responsibility does not rest on one individual or on small groups but on the whole nursing staff along with other staff who are involved. It facilitates documentation. The longer the staff teach, the more skilled they become; monitoring allows judgment of adequacy. Two disadvantages are, first, that it works less well for inpatients than for outpatients and, second, that it is not fully standardized. Future plans include an assessment format, help with communications media, the use of computers, and further research on methods. Apparently the program works very satisfactorily and very effectively in this setting.

Dr. Donald Bosshart, who has a degree in education and has charge of curriculum planning for the Northeast Ohio Medical School, talked on the physician-patient encounter. He reported that his principal problem is with physicians. The variables that predict that a physician will be an effective change-agent, he believes, are his ability to gain insight into a patient's problem-solving process and, second, to adjust his own approach to the patient's level of function. Patients expect their physicians to be doctors, i.e., teachers, but physicians think of themselves as diagnosers and treaters. There is some multiplicity of expectations and a very short time in which to accomplish anything during the encounter. There is a desire on the part of both patients and physicians to maintain mystery and magic.

Failure is a salient feature of the relationship in that it is a threat to both the patient and the teacher. Records are often lacking. Some students are not motivated, and physicians are unlikely to modify the approach to the patient if the patient differs from their expectations. Only about 50% of information that is communicated is retained for any length of time. Physicians are unwilling to acknowledge failure and are not trained to evaluate

outcomes. They are preoccupied with other aspects of their own ego needs and tend to misinterpret communication cues. They are taught to ignore interpersonal conflicts and to avoid them.

At the close of each visit the physician should attempt to determine the level of understanding of the patient so the patient can explain it back to the physician. That way he gets a feedback curve that tells him what he has accomplished. If he cannot do it himself, he should assign this responsibility to other office personnel to obtain this feedback. And he should try to develop realistic expectations of success and confront his failure. He must provide alternatives in dealing with failure.

Dr. Charles Cohen, a social worker with the dialysis unit of Long Island Jewish Hospital in Queens Village, a satellite dialysis center, has been studying means of communicating with dialysis patients and reasons for their non-compliance. He concludes there is no single factor. One of the major problems is staff anger from frustration at lack of compliance. The patient may feel loss of control and become rebellious, and that is a source of conflict. It is important to deal with both the patient and the family. The educational process is not often focused and evaluation is overlooked. The patient's and the family's emotional adjustment may interfere. He gave some examples of the methods he uses. One of the most successful is the use of charts to explain to patients the problem of fluid transfer and why overload may be a serious problem and must be monitored and directed. He feels that monitoring patients regularly gives them a feeling of security and gives the staff clues as to what they should be concentrating on in their teaching and management. Patients respond well to visual aids, as do families. A grant is available from the Kidney Foundation for an organized audiovisual program; and he has two audiovisual tapes, 40 minutes each, which he uses with patients and family, and which also helps to educate the health care team. All this is being studied on a semiexperimental basis with 70 patients who have been on dialysis for a year. There is a compliant group and a noncompliant control. There is a pretest and a post-test.

Discussion then became general. I would not want to say that we achieved consensus, but we came to agree on some common themes that kept repeating themselves. The common themes include: All physicians are not capable of good patient teaching. Some are, however, and should be encouraged. Therefore, a team approach is desirable. The physician should be part of the team, but not always in charge of it under all circumstances. Institutional change both within the hospital and within the profession is necessary to organize good patient education. More research is needed, and in research we need

to distinguish between education and compliance because, as was pointed out, particularly by Dr. Wroblewski, that when patients get all the information they need, they should be allowed to make a decision contrary to that of the physician who is teaching them if they feel it is in their best interest. One of the biggest problems in patient education is a lack of cost incentives. For that reason, possibly that HMO pattern is a better setting for patient education because prepayment can help take care of the cost of the variety of health personnel needed.